



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

NISAL CORP  
P O BOX 24809  
HOUSTON TX 77029

#### **Respondent Name**

NEW HAMPSHIRE INSURANCE CO

#### **Carrier's Austin Representative Box**

Box Number 19

#### **MFDR Tracking Number**

M4-10-4820-01

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Our facility has sent two status requests and a request for reconsideration, all of which have not been replied to. Therefore does not give us an avenue to properly seek reimbursement for services we provided."

**Amount in Dispute:** \$800.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** The respondent signed for the Notice of Medical Fee Dispute on August 6, 2010. The respondent did not submit a response to the dispute for consideration.

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 6, 2009	97750-FC X 16 Units	\$800.00	\$521.50

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
3. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement of professional medical services provided on or after March 1, 2008.
4. No explanation of benefits was provided by either party.

## **Issues**

1. What are the requirements for an FCE per 28 Texas Administrative Code §133.204(g)?
2. Did the requestor document the following required elements of an FCE per 28 Texas Administrative Code §133.204(g) to determine this patient's functional capacity, ability to meet minimum job criteria and/or the need for rehabilitation?
3. Is the requestor entitled to reimbursement?

## **Findings**

1. The documentation submitted by the requestor in this dispute was reviewed. 28 Texas Administrative Code §134.204(g) states that "The following applies to Functional Capacity Evaluations (FCEs): Documentation is required. FCEs shall include the following elements:
  - (1) A physical examination and neurological evaluation, which included the following:
    - (A) appearance (observational and palpation);
    - (B) flexibility of the extremity joint or spinal region (usually observational);
    - (C) posture and deformities;
    - (D) vascular integrity;
    - (E) neurological tests to detect sensory deficit;
    - (F) myotomal strength to detect gross motor deficit; and
    - (G) reflexes to detect neurological reflex symmetry.
  - (2) A physical capacity evaluation of the injured area, which includes the following:
    - (A) range of motion (quantitative measurements using appropriate devices) of the injured joint or region; and
    - (B) strength/endurance (quantitative measures using accurate devices) with comparison to contralateral side or normative database. This testing may include isometric, isokinetic, or isoinertial devices in one or more planes.
  - (3) Functional abilities tests, which include the following:
    - (A) activities of daily living (standardized tests of generic functional tasks such as pushing, pulling, kneeling, squatting, carrying, and climbing);
    - (B) hand function tests that measure fine and gross motor coordination, grip strength, pinch strength, and manipulation tests using measuring devices;
    - (C) submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill; and
    - (D) static positional tolerance (observational determination of tolerance for sitting or standing)."
2. The requestor's documentation was reviewed. The requestor's submitted documentation sufficiently supports the requirements of an FCE were met in accordance with 28 Texas Administrative Code §134.204(g). 28 Texas Administrative Code §134.204(g) states, in pertinent part, that "FCEs shall be billed using CPT Code 97750 with modifier 'FC.' FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title." Further review of the requestor billed for 16 units of CPT code 97750-FC; however, the FCE report states the evaluation time was 12:30 pm – 3:30 pm, for a total of 12 units. Therefore, this dispute will be reviewed according to applicable rules and Division fee guidelines.

3. Per 28 Texas Administrative Code, Section §134.203(c)(1) the calculations for CPT code 97750-FC x 10 Units is as follows:

CPT Code 97750-FC x 12 Units: \$53.68 WC CF/36.0666 Medicare CF x \$29.20 Participating Amount  
= \$43.46 x 12 Units = \$521.50

The total MAR for CPT code 97750-FC x 12 Units rendered on November 6, 2009 is \$521.50.  
Therefore, this amount is recommended.

## **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$521.50.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$521.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### Authorized Signature

_____	_____	February 16, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**